

Washington State Preliminary Plan For Diabetes Prevention and Control August 2004

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Introduction

The Washington State Diabetes Prevention and Control Program (DPCP) started the assessment and planning process for the State Diabetes System (SDS) in mid-2003 with an assessment process using a customized version of the state level assessment instrument developed by the U.S. Centers for Disease Control and Prevention. In March 2004, a system mapping session was held to address one of the major issues articulated during the assessment: that there was no comprehensive description of the SDS. This resulted in the development of four sector maps, a geographic map, and a target audience map for the SDS. The development and planning phase for the state plan culminated in a formal planning retreat process in June 2004. This effort included the results of the Fall 2003 performance assessment process and the March 2004 system mapping workshop. The DPCP and the project steering committee engaged consultants from MCPP Healthcare Consulting to design and conduct the state plan development process and report.

State Plan Development Process

A unique feature of the development of the preliminary state plan was the broad scope of participation from many parts of the State Diabetes System; including federal, state, and local public health staff, private organization staff, and representatives from volunteer organizations. The two-day planning retreat was conducted twice, first in Seattle on June 7-8, 2004, with 31 participants from throughout western Washington, and on June 21-22, 2004, in Spokane, for 18 participants from the eastern part of the state.

The retreats started with a short orientation to the 10 essential services, the summary findings and recommendations of the performance assessment process, and a review of the sector, geographic, and target audience maps, and the system alignment wheel. Approximately a third of the participants had been involved in either the assessment process or the mapping workshop prior to these retreats. The consultants then facilitated the process to establish a goal statement and objectives for each of the recommendations from the assessment retreat. Following the two retreats, the consultants collated and synthesized the goal and objectives statements from both retreats into a single state plan document that was reviewed and revised by the DPCP staff.

Preliminary State Plan

This report, the Washington State Preliminary Plan for Diabetes Prevention and Control, includes the goals and objectives developed in the retreats for the State Diabetes System, the goals alignment wheel, and the revised sector, geographic, and target audience maps. The goals and objectives are comprehensive and directly address 9 of the 10 Essential Services for public health. The high level of participation and engagement in the planning retreats increased the alignment and partnership among the public, private, community-based, and academic partners and will be an asset in the implementation activities for the Washington State Plan for Diabetes Prevention and Control. The initiatives described in this preliminary plan and the commitment of the system partners to the design and improvement of coordinated and effective services will enhance the quality of life for the residents of Washington State with diabetes.

Essential Service #1: Monitor health status to identify health problems.

Goal 1: An integrated surveillance system is supported that is compliant with the 1996 federal Health Insurance Portability and Accountability Act (HIPAA) and that provides consistent information for everyone.

Objectives

- 1) Establish a statewide coalition work group to oversee implementation of this goal and tie it into the statewide plan**
 - a) Identify all partner and Department of Health (DOH) databases, assess and validate data elements, and plan for integration and addressing redundancy in the surveillance system.
 - b) Conduct an overview other states' activities (e.g., Indiana master registry) and emerging practices.
 - c) Develop and implement a mechanism to assure input from and feedback to the regional coalitions (see Goal #4).
 - d) Assure that the surveillance system and all contributing databases are HIPAA compliant.
- 2) Improve access to and use of existing data systems through development of data sharing agreements and working with existing partner systems including, but not limited to Indian Health Service, Centers for Medicare and Medicaid Services (CMS), and health plans.**
 - a) Identify and assess clinical databases/electronic medical records (EMRs)/registries from all system partners (including tribal health aggregate data) as potential data sources.
 - b) Analyze health disparities data and demographics across all databases (see Goal #6).
 - c) Assure that all data are complete, annotated, accurate, useful, and timely.
 - d) Identify data gaps (such as emergency rooms) in the system and address issues including accuracy of coding, differing populations, lack of standard definitions, clinic specific approaches, and at-risk populations.
 - i) Estimate how many people do not have a health care provider (including data from the Behavioral Risk Factor Surveillance System (BRFSS) survey.
 - ii) Collect data for ethnic populations.
 - e) Tie data collection to screening initiatives to create a database to capture screening outcomes and follow up (see Goal #2).
 - f) Consider website access to interactive data, a data warehouse, links to data not in warehouse, and assure that data are available in PDF files that can be downloaded for secondary analysis (See Goal #4).
 - g) Consider using a separate sub-group to oversee the improvement of data accessibility, reports, and report dissemination.
 - h) Organize state-level data to support regional coalitions and community efforts and to provide regular published reports (comparisons, trends, and regional, community, and state rates).
 - i) Provide technical assistance to regional coalitions and communities on use of data.

- 3) Prioritize the establishment of registries and/or EMRs in every primary care practice in the state.**
 - a) Assure the usefulness for clinical practice.
 - b) Spread registry concepts, then compile the data similar to Cancer Registry processes.
 - c) Work with associations, such as the Medical Group Management Association and the Association of Rural Health Centers, to understand and participate in efforts to implement and use data from EMRs.
- 4) Create a database that captures information about people with undiagnosed diabetes, high risk factors, and pre-diabetes.**
 - a) Determine the goals for use of this data to clarify what is needed including the adoption or development of indicators for non-identified diabetes (see Goal #2).
 - b) Track changes in newly diagnosed populations to determine whether trends are consistent with prevalence projections).
- 5) Assess feasibility of modifying existing/emerging surveillance approaches and the environment for electronic submission of data from providers in Washington.**
 - a) Evaluate emerging approaches, including the potential for the National Health and Nutrition Examination Survey (NHANES) bio-sampling process, BRFSS, and community assessments conducted by local public health jurisdictions.
 - b) Study incentives such as making chronic diseases “reportable” and California’s paying for performance initiative.
- 6) Assure resources for system development and that the surveillance is supported with appropriate staff and resources.**
 - a) Secure funding and dedicated staff.
 - b) Integrate CMS initiatives and information technology standards.

Key idea and for future consideration:

- A key purpose is to improve understanding of the demographics and other data regarding people with undiagnosed diabetes, pre-diabetes, newly diagnosed diabetes, and populations experiencing disparities.
- “Mine” encounter data.
- Improve quality of other source systems (e.g., death certificates).
- Explore registry-based data risk profiles.
- Expand data collected through BRFSS.
- Analyze and use data from laboratories.
- Reduce proliferation of registries.
- Determine how to work with and report small numbers.
- Monitor health transition from risk factors to disease to disease management and utilization of all services, ideally tracked from behaviors to death.
- Consider all chronic diseases.

Essential Service #2: Diagnose and investigate health problems and health hazards.

Goal 2: Comprehensive, evidence-based, and ongoing screening activities are conducted in all high-risk populations, using multiple sites and methods, that identify new cases of pre-diabetes and diabetes for the purpose of diagnosis and intervention.

Objectives

- 1) Identify barriers to screening for hard-to-reach populations**
 - a) Request the American Diabetes Association (ADA) to identify standards for pre-diabetes and Type 2 diabetes at all ages.
 - b) Disseminate science-based standards for screening for Type 2 diabetes to:
 - i) Health plans
 - ii) Health care providers
 - iii) Policy makers
 - c) Support regional coalitions in conducting analyses for the hard-to-reach populations in their regions.
- 2) Publicize the need and provide the means to get risk factors disseminated through multiple novel ways that are culturally appropriate (see Goal #3, Objective #1). These include**
 - a) Motor vehicle licensing for young males
 - b) Employers, such as Boeing and health plans
 - c) As measured through volume and diversity (see Goal #6).
- 3) Identify and implement an action plan to increase providers' knowledge of high-risk populations, and increase the ordering of glucose screening for all at-risk patients.**
- 4) Motivate individuals to ask providers for regular screening and assure that all people newly screened with high risk for diabetes receive info to empower them to seek appropriate diagnosis and treatment by:**
 - a) Adding body mass index (BMI) and Fasting Glucose to "Know Your Numbers" campaign
 - b) Identifying 3–5 actions that people screened at high-risk for diabetes can take for follow-up.
 - c) Communicating the five things you can do ("you are not alone—you can go to") and the ADA website and other contact information.
- 5) Partner with employers to increase screening of their employees while assuring compliance with HIPAA.**
- 6) Develop and communicate referral and follow-up procedures and resources to all practitioners for pre-diabetes or those newly diagnosed with diabetes to get education, prevention, and treatment services.**

- a) Link to regional and community services for diagnosis and treatment (see Goal #1, Objective #4).

Essential Service #2--Key Ideas and for Future Consideration:

- Request funding for, and conduct, barrier analysis regarding diagnosis and treatment (one-year action).
- Build on the lessons learned of the national pilots.

Essential Service #3: Inform, educate, and empower people about health issues

Goal 3: A comprehensive, coordinated, and measurable strategy is conducted to increase awareness of risk factors for diabetes and to empower individuals to take action to prevent diabetes, get screening, diagnosed, and receive treatment to manage their diabetes.

Objectives

- 1) Create a marketing plan to increase consumer demand for screening for diabetes through an advertising campaign that uses multiple, validated methods to communicate key messages (see Goal #2, Objective #2).**
 - a) Key messages should be customized to address cultural, linguistic, and gender issues. They should be specific to individual's behavior, include "You are not alone—you have a health care team to help you," and focus on prevention activities such as increased activity, nutrition and weight.
 - b) Assure that consumer communication considers research and evidence-based findings.
 - c) Prioritize the more affordable opportunities and address the multiple components of the change continuum.
 - d) Investigate the use of innovative locations and methods for communicating the messages such as:
 - i) Monthly news bulletins
 - ii) Restaurant notices similar to "Don't drink if you are pregnant."
 - iii) Fitness and health clubs
 - iv) Theaters
 - v) NASCAR races
- 2) Assure that individuals and system partners know what resources are available to them for screening, diagnosis, and treatment of diabetes, as measured by every group having information available (see Goal #4).**
- 3) Enable system partners (such as tribes) to be the marketing arm for their constituencies (see Goal #4).**
 - a) Other stakeholders have the capacity and skill to communicate messages to the media.
 - b) All partners know and use the National Diabetes Education program (NDEP) clearinghouse.
- 4) Partner with pharmacy companies and health plans to sponsor awareness activities for diabetes risk factors and the importance of screening (see Goal #4).**

Essential Service #3--Key Ideas and for Future Consideration:

- Do the at-risk know who they are?
- Create activated, empowered consumers.
- Our long-term goal should be to be able to say "we're out of business."
- Use common messages over time with multiple sources.
- Devise a set of common messages we all support.

Essential Service #4: Mobilize partnerships to identify and solve health problem.

Goal 4: A statewide coalition is supported that includes a broad range of traditional and non-traditional partners to maximize collective resources and to and to encourage regional and community collaboration for state plan implementation, evaluation and improvement.

Objectives

- 1) Build statewide and regional coalitions to initiate and coordinate diabetes-related activities on the state, regional, and local levels.**
 - a) Convene an initial planning committee for forming a statewide coalition.
 - b) Include broad representation of key stakeholders and level the playing field so non-traditional partners feel empowered to participate. Bring national experts and resources in to educate all members.
 - c) Be clear about the coalition's purpose, including having the statewide coalition oversee the statewide plan and coordinate efforts, lead partnership development, identify incentives, and a share leadership role with communities.
 - i) DOH would act as a convener, but over time, leadership could be rotated or placed elsewhere.
 - d) Develop structure (large group or executive committee), roles, and responsibilities of members.
 - e) Combine regional and sector representation on the statewide coalition, and maintain a representative steering group with everyone having equal vote,
 - i) Identify existing DOH coalitions,
 - ii) Engage the ADA.
 - f) Determine how to staff the process and do the work.
 - g) Initiate a process to create regional coalitions using the hub concept. Identify regions by grouping counties that cluster with an urban core, and spread access to resources out to rural and remote areas (look at existing regions used by DOH programs and care seeking patterns of the population).
 - i) Tribes statewide could be a regional coalition.
 - h) Identify partners in regional and community efforts (e.g., schools, health districts) and engage people not now engaged, including consumers.
 - i) Identify regional conveners.
- 2) Develop a statewide plan that is shared by the coalitions.**
 - a) Develop a vision, mission, values, and principles as part of the statewide plan.
 - b) Engage regional coalitions early in the process of developing and commenting on the statewide plan, regions then develop specific activities that move the plan forward.
 - c) Investigate the use of cause/effect facilitation to set priorities and use of a logic model to develop further all objectives in the statewide plan.
 - d) Regional coalition plans roll up to the statewide plan with regional priority-setting as part of development of its development.

- i) As in AIDS Net or asthma initiative models, link state and regional or community activities with different activities at each level that link to the whole.
- ii) Share goals and objectives, but each region or community moves objectives forward in ways unique to its needs.
- e) Action steps of the plan are measurable and have regular updates of progress, including cause, barrier, and gap analysis when objectives are not met.
- f) Finalize and adopt the goals and objectives of the statewide plan with links to partner plans by identifying the activities their organizations are doing that move the shared goals and objectives forward.
- g) Finalize, implement, monitor, and revise the statewide plan. It is a dynamic document that is reviewed annually, evaluated regularly, and whose achievements are noted and celebrated.

3) Develop the system mapping process, identify new partners, and invite them into the process.

- a) Document what we have now and who is doing what.
- b) First complete state level maps, then look at regional and community coalitions, and provide state mapping information to them to help them identify regional and community partners.
- c) Broadly disseminate the system maps.
- d) Take maps to conferences not usually attended, and seek new partners.

4) Identify resources that will support regional/community coalitions.

- a) Assess current involvement and activities in each region, and have regional resource maps based on statewide maps.
- b) Assure that inter-regional connections and shared tools and processes are initiated and practiced (e.g., ESL unit on diabetes).
- c) Secure seed money for regional and community coalitions to support staff and consumer participation, among other needs.
- d) Mobilize regions to be conduits of information for providers, to build relationships with clinic partners, and to act as collaborative participants.
- e) Maintain a website and other communication mechanisms.

5) Develop and implement a statewide coalition communication plan that brings together information about all of the resources and activities.

- a) Connect with others who have done the work, network, and spread regional/community ideas.
- b) Engage people who may never come to a meeting.
- c) Assure that all partners know what is going on, regionally and statewide.
- d) Communicate the statewide plan to the leadership of partner organizations.
- e) Disseminate initiatives and data reports to a broader scope of partners (see Goal #1).
- f) Hold an annual conference with focused small groups, or use technology opportunities to convene and share information.
- g) Tie into other events, conferences, and state and national events.
- h) Establish media links for national events and efforts to reach nontraditional partners.
- i) Support communication efforts by funding and hiring a dedicated person focused on communication plan implementation.

- 6) **Expand regional/community capacity for community mobilization specific to primary prevention and control.**
 - a) Use multiple methods and adopt proven processes for addressing needs for increased capacity such as:
 - i) Principles from Healthy Communities and STEPS spread to other sites and used by regional coalitions
 - ii) Facilitators trained by Group Health Living Well with Chronic Conditions program can work with groups over the planned sequence of meetings.
 - b) Build on existing coalitions and adapt diabetes issues as part of larger efforts.
 - c) Permeate the health care delivery system with the chronic care (cc) model.
- 7) **Create a clearinghouse website and list serve.**
 - a) Assure that various sections of the website can be accessed by different users.
 - i) Partners can access an overview of all current activities and work, statewide plan/coalition update, data, contacts, resources, and key issues (see Goal #1).
 - ii) Regional coalitions might have separate pages, "rolling up" reports from programs to regions, to state level.
 - iii) Public can access educational information.
 - b) Collect ideas and best practices from across the state, and assure that all partners and providers can access best practices, with tools and materials to review and adapt.
 - c) Create links to state and national resources (DOH, diabetes collaborative, state diabetes program).
 - d) Build in a quality assurance process for the clearinghouse and assure the system is regularly maintained.
- 8) **Evaluate the statewide and regional coalition process itself to see if it has made a difference.**
 - a) Evaluate the 2000-04 plan and have an evaluation plan in place for the new statewide plan that includes public, private, and community-based organizations and provides for an academic evaluation (see Goal #9).
 - b) Identify achievements and celebrate them.
- 9) **Create an anticipatory planning process for new opportunities and emergent problems within DOH, across programs and with other partners (e.g., the state Office of Superintendent of Public Instruction).**
 - a) Assure that the planning process has the flexibility to address a situation that "bends the rules."

Essential Service #4--Key Ideas and for Future Consideration:

- Include everyone interested in participating, expand membership, and identify new entities and partners.
- Consider establishing a future DOH chronic disease advisory board, possibly with disease-specific subgroups.
- In the statewide coalition, start with a focus on diabetes, but make clear that the long-term intent is to focus on chronic disease and integrate efforts. Each region would move toward this integration at the pace that works in its group.

- Assure representation of diverse populations, so the system works to reduce barriers.
- Establish a statewide website as an opportunity to comment and review documents, CDC links, etc. Focus on communication rather than meetings and committees; use creative technology.
- Encourage collaboration among the diabetes coalitions and with other coalitions.
- Encourage collaboration with non-traditional partners.
- Maximize private and community partnerships, including businesses.
- Build a sense of being part of larger system, connected, with a common vision.
- Assure access to shared resources, maximize resources (people, money), and reduce duplication,
- Assure access to shared knowledge, information, and data.
- Encourage shared decision-making and evaluation.
- Seek expanded resources for the system.
- Provide clear definitions.
- Be aware of regional/community differences in focus of work.
- Define the partnership model.
- Use evidence-based interventions.
- Identify networks unique to communities.
- Create an informed citizenry making good choices.
- Bring in the private practice community that is not part of larger delivery systems.
- Look ahead to the community eventually mobilizing itself, building community capacity and coalitions.
- Identify common work across chronic disease.

Essential Service #5: Develop policies and plans that support individual and statewide health efforts.

Goal 5: In recognition of the financial and human impact of diabetes, state, local, tribal, and business entities develop policies and allocate appropriate funding to support diabetes prevention and management in Washington State.

Objectives

- 1) Quantify the return on investment (ROI) to key stakeholders of funding and coverage for diabetes interventions. Calculate the direct and indirect cost of pre-diabetes and diabetes, both undiagnosed and diagnosed, and quantify the expected impact, including the cost of applying appropriate, evidence-based interventions for successfully reducing costs of the disease and increasing the quality of life and productivity of individuals.**
 - a) Consider requesting that the state develop and implement incentives for other key stakeholders in supporting diabetes activities.
 - b) Develop and implement a cost-effective, evidence-based plan to decrease the burden of diabetes and produce greater ROI for stakeholders
- 2) Target Washington’s Health Care Authority (the largest purchaser of health coverage in the state) to fund and support diabetes screening, diagnosis, and treatment activities for covered employees.**
- 3) Build “business case” measures into surveillance and program evaluation processes (see Goals #1 and #9),**
- 4) Develop and implement a communication/marketing plan to promote and sell the business case to all identified key stakeholders (see Goal #4).**
- 5) Provide data and information to the state and other major purchasers to support their reimbursement policies in response to the demonstrated improvement in outcomes and health indicators.**

Goal 6: The state plan supports evidence-based, culturally and linguistically appropriate, and sustainable strategies that affect social determinants of health and reduce disparities in health outcomes.

Objectives

- 1) Develop and implement short- and long-term primary prevention activities and strategies to conduct outreach to ethnic and other communities with disparities.**
 - a) Explore interventions addressing social and environmental determinants of health that will reduce health disparities
 - b) Reinforce and empower regional/community leadership in their activities and encourage work with non-traditional community partners to increase community capacity (e.g., SE Seattle model, Active Living Leadership).

- c) Use innovative methods for reaching disparate populations, including peer mentors, and adapting or adopting best practices, possibly from other chronic disease initiatives.
- 2) **Spread and adapt evidence-based community interventions to create a statewide secondary prevention program.**
 - a) Identify best strategies, including a compendium of evidence-based approaches and lessons learned, successes from existing pilots, targeted to differing groups and communities; such as REACH and other culturally and linguistically appropriate examples.
 - b) Link interventions with current and ongoing research to create innovative approaches.
 - 3) **Provide information and education to communities (including policy makers, funding sources, and individuals) about health disparities and social determinants of health.**
 - a) Information and education on risk factors (both problem and strategies) and the positive messages about return to health
 - i) We do affect others around us in cost of disease.
 - ii) Parents and impact on kids' habits and behaviors
 - b) Address cultural norms (see Goal #3).
 - c) Show respect for community decisions and priorities.
 - 4) **Engage and give voice to people and communities affected by health inequities in development of the statewide plan.**
 - 5) **Assess the barriers to quality care for all populations, using a person-centered process, and educate health care providers to reduce barriers and provide culturally competent care.**
 - a) Find out what people, especially those at risk, say about why they do not seek and use health care services (see Goal #10).
 - b) Develop educational programs for providers, using assessment and best practice information for culturally competent care.
 - 6) **Develop mechanisms for health promotion that address the social determinants of health (environment, policy) and are not solely reliant on the health care delivery system**
 - a) Coordinate with state physical activity and nutrition and cancer control plans.
 - b) Support community examination and planning and policy development for change regarding poverty, education and other systems, open space, and safety.
 - c) Address the realities of families living with many pressures, the need to create hope and partnership for one's own health, and change unhealthy cycles that affect children.
 - 7) **Develop a database to support efforts to address disparities, and assure that regional coalitions access data sets that allow them to plan, track, and develop policy recommendations in regard to disparities (see Goal #1, #9, and #10).**
 - a) Define target populations, develop more specific data, and communicate these data to communities (see Goal #1).
 - b) Work with the research community across the state (see Goal #10).
 - c) Educate providers about disparities.
 - d) Monitor effective evidence-based strategies (see Goal #9).

Essential Service #5--Key Ideas and for Future Consideration:

- This is a national teachable moment, and we need consistent messages for the community level and statewide.
- Specify the higher-risk populations and support more aggressive strategies for them.
- Conduct primary as well as secondary prevention.
- Value self-determination.
- Ensure social justice.

Essential Service # 6: Enforce laws and regulations that protect health and ensure safety.

No goals or objectives are related specifically to this essential service.

Essential Service # 7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable.

Goal 7: A partnership is maintained between the statewide coalition and other entities that works toward a solution to primary care access, while also using the Institute for Healthcare Improvement (IHI) Collaborative model to improve access in existing clinics through operational improvements.

Objectives

- 1) Develop strategies at the regional coalition level, in partnership with the provider community, related to access to care for those who are uninsured and low income, or who are insured but without a medical home.**
 - a) Develop a list of referral resources and maximize use for those needing uninsured care.
 - b) Look beyond the medical model to preventive and self-management activities and provide information and options to link people to chronic disease self management programs and teach them to manage their health.
- 2) Develop approaches to address barriers to care for people who may have access but may not use it, especially through communication with ethnic groups (see Goal #6).**

Essential Service #7--Key Ideas and for Future Consideration:

- Partners include the Washington Health Foundation and the State Board of Health.
- Many working families are low income and have sporadic or no health coverage.
- Retired people may not have coverage from employers.
- Community health centers are not adequately resourced.
- Various community solutions and free clinics but not in sufficient number to meet need.
- According to the *Urban Institute Tabulations from the 1997 National Survey of America's Families*, there is roughly the same number of uninsured people as there are Medicaid enrollees in Washington State. (about .5 million). National trends suggest this number has increased since 1997.
- Local public health jurisdictions are no longer “the providers of last resort” to indigent populations.
- People without access to primary care also lack access to health education.
- Lack of access results in the inefficient use of emergency rooms.

Essential Service #8: Assure a competent public and personal health care workforce.

Goal 8: An expanded, more knowledgeable health care workforce is supported through a planned, comprehensive, statewide program to increase the skills and knowledge of professional, allied health, volunteer, and lay persons in delivering diabetes-related education, screening, diagnosis, and treatment services.

Objectives

- 1) Engage more of the target workforce in the chronic care model by 2008, especially in rural areas**
 - a) Assure that past participants in the collaboratives and other types of training and certification for diabetes stay engaged in learning and increasing their skills.
 - b) Develop and implement alternative forms of the collaborative content and methods for learning and applying the CC model.
 - c) Integrate collaborative principles and activities in curricula of state professional schools (e.g., nursing, medical technology, medicine)
- 2) Assure that a range of educational opportunities are available for regular, ongoing training:**
 - a) Telehealth technology
 - b) Continuing medical education
 - c) "Mini" collaboratives for rural or other areas
 - d) MD mentor processes
 - e) CD-Rom/DVDs/web cast/ internet
 - f) Communities of practice
- 3) Make continuing education more widely available, and require health care professionals, including physicians and pharmacists, to engage in diabetes continuing education on an annual basis.**
 - a) Identify parties to receive updates on diabetes management with new tools and methods such as the American Diabetes Association booklet
- 4) Disseminate information regarding diabetes statistics and educational opportunities to build the case and to increase the motivation of individuals in the workforce to seek additional training (see Goal #1).**
 - a) Consider use of MD champions
 - b) Employ web-based communication methods (see Goal #4).
 - c) Find a coordinator/organizer for the management of the Chronic Disease Self Management Program.
- 5) Expand the pool and diversity of diabetes educators.**
 - a) Increase knowledge and skill of allied health professionals through train-the-trainer approaches.
 - b) Promote—with education, training, and support—the use of lay persons to support and educate persons with diabetes (e.g., REACH).

- c) Add self-assessment of competence of health care practitioners for delivery of diabetes care into continuing education objectives.

6) Develop a state diabetes delivery system that pays for performance / reimbursement with recognition for populations served (Link to Goal #5)

Essential Service #8--Key Ideas and for Future Consideration:

- Finance the use of technology for increased workforce skills and knowledge.

Essential Service #9: Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

Goal 9: A systematic approach to evaluating the State Diabetes Network and the goals and objectives of the state plan is conducted and results in performance improvement over time.

Objectives

- 1) Develop an overarching logic model for the population covered by the state diabetes network and look at large-scale indicators as well as specific measures for objectives and programs.**
 - a) Establish outcomes and/or benchmarks and indicators to measure performance (e.g., increased identification of undiagnosed, reduced complications in diagnosed, and reduction in prevalence in population).
 - b) Develop the goals, benchmarks, and indicators with input from multiple partnership sources and assure they agree.
 - c) Tie to the mission and vision of the statewide plan.
- 2) Develop measurement methods that assure data can be gathered with ease and simplicity.**
 - a) Gather data or “mine” existing data sets, including claims, pharmacy, lab data, and registries to capture all existing relevant data (see Goal #1).
 - b) Engage partners in understanding the measurement process by assuring that methods are clear and evident to everyone--no “black box.”
 - c) Look at quality of life as well as cost (CDC measures).
- 3) Assure capacity to monitor the indicators in the business case and use evaluation reports to affect policy and funding at the state and national level (see Goal #5).**
- 4) Assure all initiatives have an evaluation component.**
 - a) Define it, define how to measure it, and assess if you can afford it.
 - b) Think through the appropriate level of evaluation for the project (e.g., don’t need to heavily evaluate the importance of brakes on bicycles to support the need for them).
- 5) Provide technical assistance and toolkits to regional coalitions, communities, and organizations to evaluate their objectives and activities**
 - a) Regional coalitions develop evaluation capacity.
 - i) Assess current evaluation and quality improvement capacity of regional partners.
 - ii) Assess current evaluation and QI capacity of education and care delivery organizations.
 - iii) Raise the overall level of evaluation.
 - b) Promote best practices and learning from other locations.
 - c) Build on CDC work, website access to best practices (see Goal #4).
 - d) Assess needs for technical assistance.
 - e) Early involvement in projects to develop the evaluation plan (comparative benchmarks where possible).

- 6) Communicate regarding initiatives underway and evaluation findings to all state and regional partners.**
 - a) Crosswalk to the communication plan (see Goal #4), disseminate reports.
 - b) Provide feedback and acknowledge successes.
 - c) Update referral mechanisms and regional/community initiatives to include evaluation findings about effective programs.
- 7) Establish a formal evaluation plan of the state plan with timelines and accountabilities.**
 - a) Identify how evaluation is to be done.
 - b) Disseminate evaluation plan to all parties at beginning of process.
 - c) Evaluate participation in the plan.
 - d) Repeat assessment using CDC structure, and measure against baseline data from Fall 2003.
- 8) Use the results of evaluation reports and analyses to modify and improve state and regional initiatives and to decrease duplication or ineffective programs.**
 - a) Use the adopt/adapt/abandon method by evaluating and answering the “So what?” question as part of the evaluation process.
 - b) Identify what has been learned, especially the “pearls” of wisdom.
 - c) Disseminate through the communication plan (see Goal #4, Objectives 5 and 7).

Essential Service #9--Key Ideas and for Future Consideration:

- What did we say we would do, did we do it, and what was the impact?
- Focus on the goals and objectives of the state plan, assure the action steps are measurable, and focus on measuring the business case.
- Use the plan-do-study-act (PDSA) cycle.
- Adjust and revise accordingly.
- Everyone needs to be engaged and understand total population impact.
- Observe, five years from now, what has happened to the entire population.
- Conduct both short- and long-term activities.
- Develop a project management plan.
- Evaluate implementation of the state plan and its goals and objectives.

Essential Service #10: Research for new insights and innovative solutions to health problems.

Goal 10: The Statewide Diabetes Network is knowledgeable of state and federal research projects and results. Research results are used to guide the network's policy and applied to clinical practice through active dissemination of innovative knowledge, methods, and tools to prevent diabetes and to improve the quality of life for people with diabetes.

Objectives

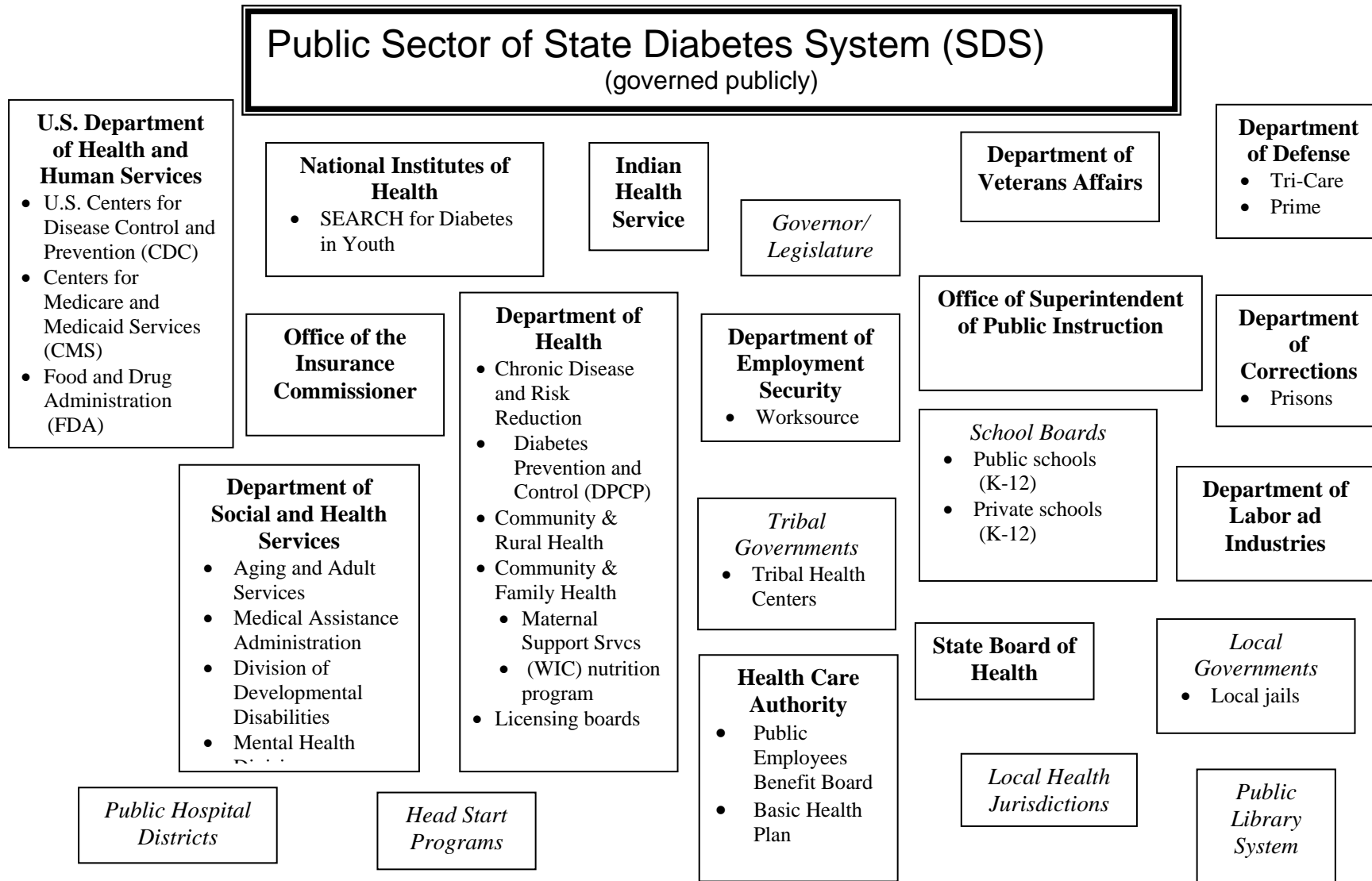
- 1) Develop, implement, and maintain, with an identified partner in the diabetes system, a focused clearinghouse of diabetes research and results, including matching capability and function and relevant national and state research (see to Goal #4).**
- 2) Establish a sub-group of the statewide coalition that includes identified research partners (including pharmaceutical) to develop the state's diabetes research agenda and goals for the diabetes system. The research agenda is focused on (see Goal #4):**
 - a) Evaluating activities for performance gaps in the 10 Essential Services
 - b) Behavioral and motivational research
 - c) Economic impact and the business case for diabetes activities
- 3) Disseminate all project results through multiple channels to all appropriate system partners.**
 - a) Consider using the state and regional coalitions to sponsor an annual research forum to share information.
 - b) Prepare press releases and reviews of journal articles.
 - c) Maintain a list serve (see Goal #4).
- 4) Create a process to link community programs back to research (arm's length, independent review board) when no efficacy information is available, and educate network partners to encourage linking with research before programs (as distinct from evaluations) are initiated.**
 - a) Research resources are available for technical assistance and consultation to communities.
- 5) Implement projects relevant to the research agenda through partnerships with researchers and funding sources.**
- 6) Partner with other states to influence national groups to maintain a clearinghouse, with appropriate links on national research entity websites.**
- 7) Reflect research results in policy changes for the diabetes network as measured by inclusion in the policy development and review process.**

Essential Service #10--Key Ideas and for Future Consideration:

- Link to federal research agenda.
- Offer internship opportunities to students, and offer students to regional/community community projects.

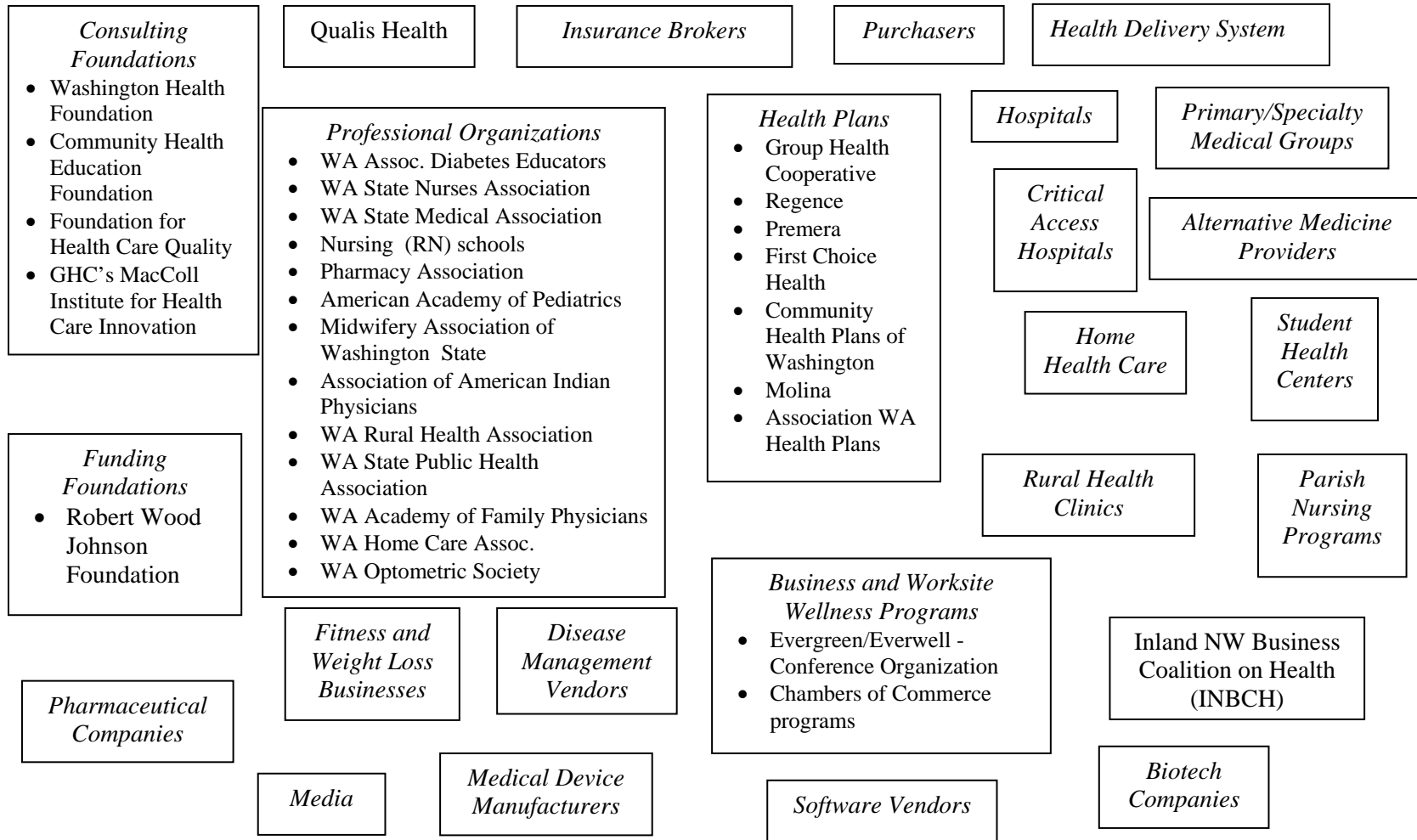
Attachment A

[Back to Table of Contents](#)



These are examples of partners in the State Diabetes System. **Bold**=large agency or organization; *Italics*=type of organization, not a specific entity; regular=specific organization or entity
Bullets refer to examples of organizations and are not a comprehensive listing.

Private Sector of SDS (governed privately)



These are examples of partners in the State Diabetes System. **Bold**=large agency or organization; *Italics*=type of organization, not a specific entity; regular=specific organization or entity
Bullets refer to examples of organizations and are not a comprehensive listing.

Community-Based Sector of SDS

(governed by community boards)

Service Organizations

- Thousands of community-based agencies in Washington: specific partners will be identified in each community

American Diabetes Association

Senior Centers

Community Centers

Community Health Centers

- Federally Qualified Health Centers
- Migrant Health Centers

United Way

American Association of Retired Persons

Choice Health Network

Communities of Color Organizations

- Asian Pacific American Resource Network
- La Raza
- Tri-Cities - National Diabetes Education Programs (NDEP) Coalition
- Yakima - NDEP Coalition
- NAACP
- Blacks In Government (BIG)
- Urban League
- Spokane Native Project
- Martin Luther King Center

Juvenile Diabetes Research Foundation

Public Health—Seattle & King County, Racial and Ethnic Approaches to Community Health (REACH)

Community-based Daycare Sites

- All ages
- Birth to 3 childcare

Faith-based Community Organizations

- Coalition on Health Environments Research (CHER)
- Catholic Community Svcs

Youth Associations

- YMCA/YWCA
- Boys & Girls Club
- Boy & Girl Scouts of America
- Campfire Girls and Boys

Youth Sports Associations

- Little League
- Pop Warner
- Soccer, etc

Service Clubs and Lodges

- Moose, Elk
- Rotary
- Lions

Community Health Alliances

- Benton-Franklin Health Alliance

Churches, Temples & Mosques

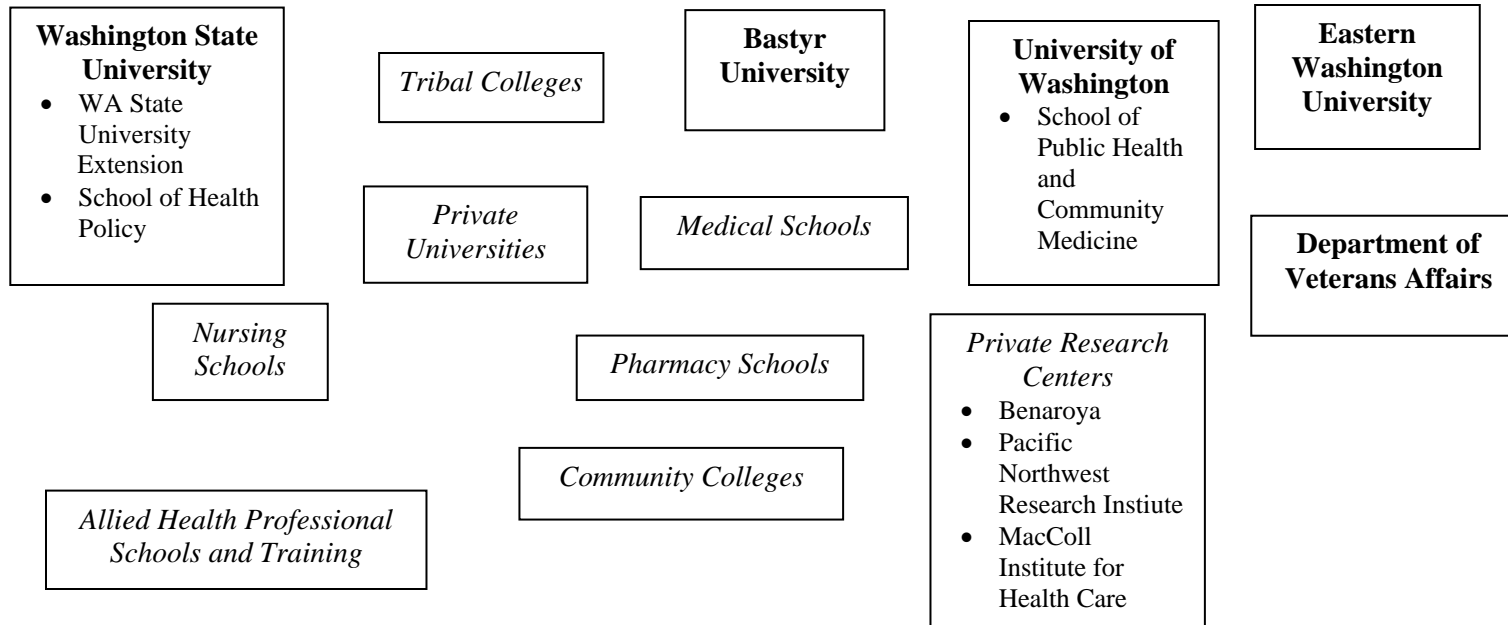
- Spokane Russian / Slavic
- Mt. Zion Baptist

State Organization of Public Health Educators

These are examples of partners in the State Diabetes System. **Bold**=large agency or organization; *Italics*=type of organization, not a specific entity; regular=specific organization or entity
Bullets refer to examples of organizations and are not a comprehensive listing.

Academic Sector of SDS (Training/Research)

(governed by various boards)



These are examples of partners in the State Diabetes System. **Bold**=large agency or organization; *Italics*=type of organization, not a specific entity; regular=specific organization or entity. Bullets refer to examples of organizations and are not a comprehensive listing.

Attachment B

Target Audience Map

<i>CONDITION</i>		<i>Age</i>	<i>Racial/ethnic Communities</i>	<i>Socio-economic/low literacy</i>	<i>General Population</i>
<i>Diagnosed</i>	Public:	<ul style="list-style-type: none"> Center for Medicaid and Medicare Services (CMS) DOH -- CDRRP/DPCP Public hospital districts Tribal associations Department of Veteran's Affairs. Department of Defense 	<ul style="list-style-type: none"> Washington State Department of Health- Chronic Disease Risk Reduction (CDRRP) DOH Diabetes Prevention and Control Program (DPCP) Tribal associations Indian Health Service 	<ul style="list-style-type: none"> DOH-Chronic Disease Risk Reduction (CDRRP) DOH- Diabetes Prevention and Control Program (DPCP) Department of Veteran's Affairs Maternal Support Services 	<ul style="list-style-type: none"> U.S. Centers for Disease Control and Prevention (CDC) Office of Insurance Governor/Legislature Dept. of Corrections Public Employees Benefit Board Local Health Jurisdictions
	Private:	<ul style="list-style-type: none"> Qualis Health Health plans Media Inland NW Business Coalition Alternative health providers Home health Student health centers 	<ul style="list-style-type: none"> Community Health Plans of WA – (CHPW) Association of Black Health Care Professionals Association of American Indian Physicians “Move It” program 	<ul style="list-style-type: none"> Molina health plan Community Health Plans of WA (CHPW) Disease management vendors Critical access hospitals Home Health Washington Health Foundation 	<ul style="list-style-type: none"> Professional orgs Pharmaceutical. Co Medical Supply Co. Purchasers Disease management Hospitals Critical access hospitals Primary/specialty groups
	Community:	<ul style="list-style-type: none"> Amer. Diabetes Assoc. Juvenile Diabetes Research Foundation (JDRF) Senior centers Service organizations Community Aging Service Providers 	<ul style="list-style-type: none"> Communities of color organizations Amer. Diabetes Association (ADA) CHOICE Health Comm. Health Centers (CHCs) 	<ul style="list-style-type: none"> CHOICE Health Comm. Health Centers (CHCs) 	<ul style="list-style-type: none"> Community Health Centers American Diabetes Assoc. (ADA) Nutrition & Cultures Disease Management Education Centers
	Academic:	<ul style="list-style-type: none"> WSU Extension Focused research programs, e.g., SEARCH for Diabetes in Youth 	<ul style="list-style-type: none"> Washington State University Extension Focused research programs, e.g., SEARCH for Diabetes in Youth 	<ul style="list-style-type: none"> Washington State University Extension 	<ul style="list-style-type: none"> Allied health training UW School of Medicine Bastyr University Nursing schools Private universities Pharmacology schools Community colleges Tribal colleges

CONDITION		Age	Racial/ethnic Communities	Socio-economic/low literacy	General Population
<i>Undiagnosed Diabetes</i>	Public:	<ul style="list-style-type: none"> • DOH – CDRRP/DPCP • U.S. Department of Health and Human Services (HHS) • Department. of Veteran’s Affairs • CMS 	<ul style="list-style-type: none"> • Tribal Associations. • Indian Health Services • DOH – CDRRP/DPCP • HHS • Women, Infants & Children (WIC) nutrition program 	<ul style="list-style-type: none"> • DOH-Diabetes Prevention & Control Program (DPCP) • Local health jurisdictions • WIC • Maternal Support Srvcs (MSS) 	<ul style="list-style-type: none"> • HHS • DSHS Mental Health Division
	Private:		<ul style="list-style-type: none"> • Communities of Color organizations • ADA 	<ul style="list-style-type: none"> • Washington Health Foundation 	<ul style="list-style-type: none"> • Hospitals • Primary Care/specialists • Health plans
	Community:	<ul style="list-style-type: none"> • American Diabetes Assoc. • Faith-based organizations • BMI program • WSU Extension “30-70 years” 	<ul style="list-style-type: none"> • CHCs • Faith-based organizations • Immigrant organizations 	<ul style="list-style-type: none"> • CHCs • Faith-based organizations • Homeless & Women’s shelters 	
	Academic:				
<i>At Risk / Pre-Diabetes</i>	Public:	<ul style="list-style-type: none"> • HHS • NBS for Type I Diabetes (DEW-IT Study) 	<ul style="list-style-type: none"> • DOH- Diabetes Prevention & Control Program (DPCP) • Indian Health Services • WIC • HHS 	<ul style="list-style-type: none"> • DOH- Diabetes Prevention & Control Program (DPCP) • WIC • MSS 	<ul style="list-style-type: none"> • HHS • LHJs
	Private:	<ul style="list-style-type: none"> • Inland NW Business Coalition 		<ul style="list-style-type: none"> • Washington Health Foundation 	<ul style="list-style-type: none"> • Purchasers
	Community:	<ul style="list-style-type: none"> • American Academy of Pediatrics-WA chapter 	<ul style="list-style-type: none"> • Communities of color • Community Health Centers-CHCs • Faith-based Organizations • Urban Indian Health Centers • Tribal Health Centers 	<ul style="list-style-type: none"> • Community Health Centers (CHCs) • Faith-based organizations 	
	Academic:				

<i>CONDITION</i>		<i>Age</i>	<i>Racial/ethnic Communities</i>	<i>Socio-economic/low literacy</i>	<i>General Population</i>
<i>Primary Prevention in General Population</i>	Public:	<ul style="list-style-type: none"> • Office of Superintendent of Public Instruction / schools • HHS • Aging and Adult Services 	<ul style="list-style-type: none"> • Indian Health Service • HHS 	<ul style="list-style-type: none"> • Office of Superintendent of Public Instruction • LHJs • WIC 	<ul style="list-style-type: none"> • DOH-Chronic Disease Risk Reduction (CDRRP) • DOH- Diabetes Prevention & Control Program (DPCP) • Public hospital district • Governor/Legislature • Department of Corrections • FDA • HHS • State Board of Health • County Planning Departments • City and/or county parks and recreation departments
	Private:	<ul style="list-style-type: none"> • Fitness and Weight Loss business • Media • Worksites/wellness programs 	<ul style="list-style-type: none"> • Media 	<ul style="list-style-type: none"> • Washington Health Foundation 	<ul style="list-style-type: none"> • Consulting foundations • Funding foundations • Purchasers • Media • Health plans
	Community:	<ul style="list-style-type: none"> • Community-based daycare • Community Aging Service providers 	<ul style="list-style-type: none"> • Urban Indian Health Centers • Tribal Health Centers 	<ul style="list-style-type: none"> • Youth Associations 	<ul style="list-style-type: none"> • Youth associations
	Academic:	<ul style="list-style-type: none"> • WSU Extension 	<ul style="list-style-type: none"> • WSU Extension 	<ul style="list-style-type: none"> • WSU Extension 	<ul style="list-style-type: none"> • UW Center for Public Health Nutrition

Attachment C

Geographic Map

STATEWIDE ORGANIZATIONS (covers most of the geography)	Public Sector U.S. Department of Health and Human Services, Department of Defense, FDA, National Institute of Health, Indian Health Service, Department of Health (DPCP, Community and Rural Health, Maternal Support Services, WIC), Department of Social and Human Services, Office of Superintendent of Public Instruction, Governor/Legislature, Insurance Commissioner, Department of Corrections	Private Sector Consulting and Funding Foundations (WHF, CHEF, FHCQ, McColl Institute); Qualis Health; professional organizations, pharmaceutical and supply companies, software vendors, disease management vendors, purchasers, insurance brokers, health plans	Community-Based Sector ADA, Juvenile Diabetes Research Foundation, AARP, Health Plans	Academic Sector Washington State University, University of Washington, medical school(s), nursing schools, pharmacy school(s), Bastyr University, private universities
Western Urban Hub (Bellingham to Olympia corridor, Bremerton, Vancouver)	<ul style="list-style-type: none"> • Local health jurisdictions (LHJs) • Public Health—Seattle & King County, Racial and Ethnic Approaches to Community Health (REACH) • Tribal Associations 	<ul style="list-style-type: none"> • Hospitals and critical access • Providers • Home health • Alternative medicine • Student health • Media • Fitness and Wt. Loss Business • Worksite wellness/programs 	<ul style="list-style-type: none"> • Faith-based • Youth Associations • CHOICE Health Network • Service Organizations • Communities of Color Org. • Community based daycare • Community Health Centers • Washington Health Foundation 	<ul style="list-style-type: none"> • WSU Extension • Community Colleges • Allied Health Professions Schools and Training
Western Rural/Small Cities Hubs (South and West of Olympia; Olympic Peninsula)	<ul style="list-style-type: none"> • Tribal associations • Public hospital districts • Local health jurisdictions (LHJs) 	<ul style="list-style-type: none"> • Hospitals and critical access • Providers • Rural health clinics • Home health • Student health • Media • Fitness and weight loss business 	<ul style="list-style-type: none"> • Faith-based • CHOICE Health Network • Service Organizations • Communities of Color organizations • Community based daycare • Community Health Centers • Washington Health Foundation 	<ul style="list-style-type: none"> • Washington State University Extension • Community colleges

STATEWIDE ORGANIZATIONS (covers most of the geography)	Public Sector Department of Health and Human Services, Department of Defense, FDA, Nat'l Institute of Health, Indian Health Service, Department of Health (DPCP, Community and Rural Health, Maternal Support Services, WIC), Department of Social and Human Services, Office of the Superintendent of Public Instruction, Governor/Legislature, Insurance Commissioner, Department of Corrections	Private Sector Consulting and funding Foundations (WHF, CHEF, FHCQ, McColl Institute); Qualis Health; professional organizations, pharmaceutical and supply companies, software vendors, disease management vendors, purchasers, insurance brokers, health plans	Community-Based Sector ADA, Juvenile Diabetes Research Foundation, AARP, Health plans	Academic Sector Washington State University, University of Washington, medical school(s), nursing schools, pharmacy school(s), Bastyr University, private universities
Eastern Urban Hubs (Yakima, Spokane, Tri Cities, Wenatchee)	<ul style="list-style-type: none"> • Tribal associations • Public hospital districts • Local health jurisdictions (LHJs) 	<ul style="list-style-type: none"> • Hospitals and critical access • Providers • Inland NW Business Coalition • Home health • Student health • Media • Fitness and wt. Loss business • Worksite wellness programs 	<ul style="list-style-type: none"> • Faith-based organizations • Service organizations • Communities of color organizations • Community based daycare • Community Health Centers 	<ul style="list-style-type: none"> • WSU Extension • Community colleges • Allied Health Professions Schools and Training
Eastern Rural/Small Cities Hubs (All of the rest of eastern Washington)	<ul style="list-style-type: none"> • Tribal Associations • Public hospital district • Local Health Jurisdictions (LHJs) 	<ul style="list-style-type: none"> • Hospitals and critical access • Providers • Rural Health Clinics • Home health • Student health • Media • Fitness and wt. Loss business 	<ul style="list-style-type: none"> • Faith-based • Service Organizations • Communities of Color Organizations • Community based daycare • Community Health Centers • Washington Health Foundation 	<ul style="list-style-type: none"> • WSU Extension • Community Colleges

Goals of the State Diabetes Public Health System, Aligned with the Ten Essential Services

Attachment D

